

IN THE CIRCUIT COURT OF _____ COUNTY, WEST VIRGINIA

IN RE: The Involuntary Hospitalization,
Treatment Compliance, or Temporary
Probable Cause of:

Case No.: _____ -MH(TCO/TPC) -
Criminal Case No.: _____
(if applicable)

RESPONDENT (NAME OF PATIENT)

CERTIFICATE OF LICENSED EXAMINER

West Virginia Code §§ 27-5-2, 3, & 4, § 27-5-11 and § 27-6A-1 (et seq.)

Instruction: All pages of this certificate must be fully completed.

I, _____ [Print name of Licensed Physician, Licensed Psychologist, Court
authorized Licensed Independent Clinical Social Worker, or Court authorized Licensed Advanced Nurse Practitioner with
Psychiatric Certification or Physician Assistant or Licensed Professional Counselor], do hereby certify and state as
follows:

I have personally observed and examined _____ (full name
of Respondent) whose identifying information is believed to be,

DATE OF BIRTH ____ / ____ / ____ ; WEIGHT _____ ; HEIGHT _____

HAIR COLOR _____ ; HAIR LENGTH _____ ; EYE COLOR _____

SEX _____ ; RACE _____

RESPONDENT'S LAST KNOWN ADDRESS: _____

PLACE OF BIRTH (state or country) _____

THE RESPONDENT IS: A RESIDENT OF _____ COUNTY, _____ STATE

Date of Examination: _____ Time: _____ : _____ a.m./ p.m.

The Examination was conducted: _____ by video conference _____ in person

Location of Respondent during the Examination: _____ (Location)

_____ (City) _____ (County) West Virginia.

1. I find there is reason to believe the Respondent **(initial the appropriate items below)**

_____ **HAS** mental illness _____ **HAS NO** mental illness
 _____ **HAS** substance use disorder _____ **HAS NO** substance use disorder

2. ***If the individual is being certified for substance use disorder, please fill out the following:***

I further find that the Respondent BECAUSE OF SUBSTANCE USE DISORDER:

_____ **HAS** _____ **HAS NOT** lost the power of self-control with respect to
 substance use: **(initial one)**

_____ **IS** _____ **IS NOT** in need of substance abuse services; **(initial one)**

Respondent's judgment _____ **HAS** _____ **HAS NOT** been so impaired that he/she is
 incapable of appreciating his/her need for such services; **(initial one)** and

Respondent _____ **IS** _____ **IS NOT** capable of making a rational decision in regard
 to substance abuse services. **(initial one)**

If it is applicable, please initial the following:

_____ I recommend that the individual be closely monitored because of the reasonable likelihood
 that withdrawal or detoxification will cause significant medical complications.

3. I further find that the Respondent **(initial one)** _____ **IS** _____ **IS NOT** likely to cause harm to
 himself/herself or others DUE TO HIS/HER MENTAL ILLNESS OR SUBSTANCE USE DISORDER.
4. If the selection in question 3 above is "IS," it is based on one or more of the following: **(check all appropriate
 items from the list of six items below and detail the specific facts under each checked item)**

Criminal Proceedings only – The individual is currently committed to a state psychiatric hospital in
 accordance with *W. Va. Code § 27-6A-1 et seq.*, and the individual is a foreseeable danger to self or others
 outside the hospital setting: **(describe the static and current acute and chronic dynamic risk factors for
 harm AND how the absence of the individual's personal protective strengths result in the individual
 being a foreseeable danger)**

The individual has inflicted, or attempted to inflict, bodily harm on another: **(describe)**

The individual by threat or action, has placed others in reasonable fear of physical harm to themselves:
(describe)

The individual, by action or inaction, has presented a danger to others in his or her care: *(describe)*

The individual has threatened or attempted suicide or serious bodily harm to himself or herself: *(describe)*

The individual is behaving in such a manner as to indicate that he or she is unable, without supervision and the assistance of others, to satisfy his or her need for nourishment, medical care, shelter or self-protection and safety so that there is substantial likelihood that death, serious bodily injury, serious physical debilitation, serious mental debilitation or life-threatening disease will ensue unless adequate treatment is afforded:
(describe)

5. You must complete this question if you have indicated substance use disorder in question 1.

The specific manifestations which have occurred WITHIN 30 DAYS prior to the filing of this petition/application in this action upon which my findings of substance use disorder is based are: *(Check all that apply; you MUST check at least one.)*

Recurrent substance use resulting in a failure to fulfill major role obligations at work, school or home:
(specify)

Recurrent substance use in situations in which it is physically hazardous: *(specify)*

Recurrent substance-related legal problems *(specify)*

Continued substance use despite knowledge of having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance: *(specify)*

Respondent, because of substance use disorder, has lost the power of self-control with respect to substance use, is in need of substance abuse services and, by reason of substance abuse impairment, his/her judgment has been so impaired that the individual is incapable of appreciating his/her need for such services and is further incapable of making a rational decision in regard to substance abuse services. *(specify)*

_____ I certify that the above is not due to the Respondent's mere refusal to receive substance abuse services.

6. I received information relevant to this evaluation from the following sources: *(Consult as many sources as possible; check all that apply)*
- | | | | | |
|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| ☐ | ☐ | ☐ | ☐ | ☐ |
| Respondent | Petitioner | Medical Record | Physician | |
| ☐ | ☐ | | | |
| Family Members | Other: <i>(list)</i> | | | |

7. *You must complete this question if you have indicated “mental illness” or “substance use disorder” in question 1.*

A. The specific, CURRENT, symptoms and behaviors I HAVE OBSERVED are:

[illegible]

B. Other current symptoms & behaviors relayed/presented to me by petitioners, witnesses, documents or other sources on which my finding of mental illness and/or substance use disorder is based on the following:

This image shows a single sheet of white paper with horizontal ruling lines. The lines are evenly spaced and run across the width of the page. There are no margins, text, or other markings on the paper.

C. Any medical and/or historical symptoms or behaviors prior to the past 72 hours on which my finding of mental illness and/or substance use disorder are based:

[illegible]

8. Prior history of behavior health services in the following settings:

Type of Treatment	Yes	No	Compliant Yes/No/Unknown	# of Admissions	Most Recent Provider/Hospital	Date
Outpatient						
Voluntary Inpatient or Residential						
Treatment Involuntary Hospitalization						

9. I have identified and considered less restrictive alternative forms of treatment and find that they

_____ ARE or _____ ARE NOT appropriate. Please provide detailed explanations as to why or why not each less restrictive alternative forms of treatment are or are not currently appropriate and available.

10. List all medications currently taking, or prescribed and should be taking:

Name of Medication:	Dosage:	Duration:
1.		
2.		
3.		
4.		
5.		

11. Is Medical Clearance Examination NECESSARY? (**Check one**) Yes No Unknown

If yes, has it been completed or arranged to be completed, prior to involuntary admission to a mental health facility?

Medical Screening was completed at: _____

Medical Screening arranged to be completed at: _____

12. Are there any acute medical conditions that require immediate attention? (**Check one**) Yes No

List the conditions:

13. The results of my evaluation suggest the following factor(s) are present, or have been present in the past:

(Check all that apply)

Factors	General Information <i>[check if yes, list date(s) when present]</i>
Thoughts of Suicide	Ideation _____ Plan _____ Intent _____ Other Prior History: <i>(If yes, explain/give examples)</i> Yes No _____ _____
Thoughts of Homicide	Ideation _____ Plan _____ Intent _____ Other Prior History: <i>(If yes, explain/give examples)</i> Yes No _____ _____
Head Injury/ Neurological	Type(s): _____ _____ _____
Chronic Medical Problems	Type(s): _____ _____ _____
Limitations to Support System	Type(s): _____ _____ _____
History of Legal Infractions	Type(s); Explain: _____ _____ _____
Past History of Harmful Behavior	Type(s): _____ _____ _____

14. The results of my evaluation suggest the following factors related to substance use disorder are present:

Substance	Amount	Frequency	Route/Method of Use	Date Last Used

Factor(s)	Yes	No	General Information
Public Intoxication Charges			Frequency in Past 90 Days/Dates _____
Substance Use to the Point of Incapacitation			Explain: _____ _____ _____
Employment Instability			Explain: _____ _____ _____

15. DSM/ICD - Diagnostic Impressions:

16. Clinician Rating of Treatment Needs: **(Check your impression)**

- 0: No observable seriously harmful behavior (SHB); No treatment needed.
- 1: Slight probability of SHB; Outpatient therapies needed.
- 2: Mild probability of SHB; Crisis residential unit (CRU) appropriate. 24-hour supervision needed.
- 3: Moderate probability of SHB; Immediate hospitalization in a 24-hour locked facility needed.
- 4: High probability of SHB; Should be monitored closely until hospitalized. Immediate hospitalization in a 24-hour locked facility needed.

17. Based upon such examination and the information contained in this certificate, I therefore certify as follows:

(Initial only ONE of the following recommendations)

_____ The Respondent does not require hospitalization (***probable cause or final commitment hearing***)

_____ The Respondent should be committed for further evaluation pursuant to § 27-5-3 (***probable cause hearing only***)

_____ The Respondent should be finally committed for an indeterminate period exceeding 90 days or until this order is modified by this Court pursuant to the provisions of § 27-5-4(1) (***final commitment hearing only***)

_____ If the Respondent is not currently committed in accordance with § 27-6A-1 *et seq.*, The Respondent should be fully committed for a period not to exceed 90 days as provided in § 27-5-4(1) (***final commitment hearing only***)

_____ If the Respondent is currently committed in accordance with § 27-6A-1 *et seq.*, The Respondent should be finally committed until the court determines that the Respondent's state and current acute and chronic dynamic risk factors for harm can be managed in less restrictive setting and that the Respondent's personal protective strengths are sufficient to facilitate safety to self and others in such setting as provided in § 27-5-4(1)(4) (***final commitment hearing only***)

18. ***Initial the following if ALL the matters contained in the statement are applicable.***

_____ Notwithstanding the foregoing, I further believe that the respondent's circumstances make him/her amenable to treatment upon an outpatient basis in a nonhospital or nonresidential setting pursuant to a **voluntary treatment agreement** and that appropriate outpatient services are available and recommend that the court hear evidence on this issue.

19. _____ I have explained or attempted to explain the involuntary commitment process to the APPLICANT including the loss of liberty if committed, as well as the likely risks and benefits of commitment.

20. _____ I have explained or attempted to explain the involuntary commitment process to the RESPONDENT Including loss of liberty if committed, as well as the likely risks and benefits of commitment.

21. Information regarding examiner completing this certificate: *(please print or type information)*

Name: _____

Address: *(city, state, zip)* _____

Telephone Number: _____ Registration/License Number: _____

License to Practice:

Medicine/Osteopathy/Psychiatry

Psychology

Physician Assistant

Nurse Practitioner

Counselor

Social Work

Date_____
Time_____
Examiner's Signature22. The person completing this certificate: *(check only one)*Is employed by the local Community Mental Health Center: *(insert name of Center)*_____
Has contracted to provide examinations for involuntary commitment proceeding with the local
Community Mental Health Center: *(insert name of Center)*_____
Is neither employed by nor contracts for services with the local Community Mental Health Center.If this item is checked, you **MUST** have the Community Mental Health Center complete the following:

- The examination reflected by this certificate was as required by law provided or arranged by the Community Mental Health Center or, if the examiner is neither employed or contracted by the Community Mental Health Center, the examination is APPROVED and the Community Behavioral Health Center hereby waives its duty to provide or arrange for this examination.

Date_____
Time_____
Signature of Center Representative_____
Title